AHCCCS NPI - HIPAA Consortium

October 2, 2007
2:00 PM to 3:00 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Facilitator: Lori Petre

Handouts:
AHCCCS NPI Key Updates
NPI Challenges Tracking Matrix as of 9/28/07
NPI Challenges 2, 3, 4, 5, 6
NPI Top 500 Trends - Encounter Submissions
CMS Bulletin
Meeting Minutes 6-27-07

Attendees: (based upon sign-in sheets)
Teleconference attendees are shown with an *

Abrazo Health
James Ten Eyck
Michelle Paladino
JoAnn Ward*

ADES
Barry Crum
Brian Lensch
Mark Rayapati
Carol Renslow

AHCCCS
Deborah Burrell
Bernard Chester
C. Michael Collins
Dwanna Epps
Asia Lennear
Jacqueline McElroy
David Mollenhauer
Brent Ratterree
Veronica Sambrano

Capstone
Lydia Ruiz

Care 1st Arizona
Susan Cordier
Kathy Thurman

Iasis Healthcare
Jessica Lennick
Jesse Perlmutter

Pinal County
Jennifer Schwarz

Scan Healthplan
Gene Dameron*
Tina Graham*
Jim Hasey*
Sharon Hawn*
Thomas Hoehner*
Marvin Quitoles*
Julie Shannon*

Schaller Anderson
Cindy Jackson-Smith

UHC
Mary Kaehler*

UPH
Kathy Steiner*

Arizona NPI Technical Consortium
October 2, 2007, 2:00 - 3:00 pm

The October 2, 2007 Agenda highlights updates about the challenges encountered with NPI data and the latest news from HIPAA and Provider Registration.

OVERALL NPI STATUS UPDATES — Lori Petre

Contingency Periods

With some exceptions, AHCCCS contingencies will expire 1/1/08. No changes have been documented to the AHCCCS contingency plan on the website. However, an internal version which tracks our progress to plan, is available for those who are interested.

Provider NPI Indicators

The only edits to the current list of Provider NPI Indicators on the website within the last several months have been to the Group Billing provider type to require NPI.

Follow-up Meetings

More meetings with Health Plans and contractors will be scheduled for November/December as needed, i.e., conference calls or short face-to-face meetings. These will generally occur before the contingency period expires on 1/1/08 and will address such issues as "Where we are" and "What we need to be aware of."

Top 500 Trends Reports

The Top 500 reports went out again last week. The NPI Top 500 Trends - Encounter Submissions Report handout shows the progress made at three different date periods: 5/17/07, 7/10/07, and 9/18/07. Numbers specific to any given Health Plan are also available upon request (lori.petre@azahcccs.gov).

NPIs on file that are not in the Top 500 Report should be submitted to Valerie (Attention Provider Registration) on the form previously provided.

Reminders

- Provider/Heath Plan affiliation tapes should contain NPI data, which AHCCCS will post to the provider file.
- The NPI has to be submitted as part of the registration for any provider type that requires an NPI at the point of provider registration.

Issues and Challenges Tracking

Most challenges center upon how PMMIS processes data and what AHCCCS is doing to resolve any conflicts. Fourteen challenges have been identified thus far through weekly tracking efforts by Mary Kay, Valerie, and Lori.

1. One NPI to Multiple AHCCCS ID numbers is problematic because PMMIS identifies one-to-one matching. This issue is being resolved individually for impacted providers by Valerie.
2. Multiple NPI #s to one AHCCCCS ID number is best exemplified by the hospitals, which have had as many as eight NPI numbers. AHCCCS will allow providers to have more than one NPI number for a single AHCCCS Registration number and will track accordingly. SSR# 2007-0255 has been submitted for necessary system changes.
3. Billing Provider NPIs - Issue 1 is qualified under NPI rules and stipulates that a Billing Provider cannot be restricted to correspond to an AHCCCS Provider Type 01. Previously, only Provider Type 01 could bill for another. SSR# 2007-0272 has been drafted to allow AHCCCS to recognize billing entities that can bill on behalf of other rendering providers. This means, for example, a physician will be able to use his/her physician NPI as the billing provider in the 837 transaction and bill for a PA on staff as a Rendering

Provider. In Trading Partners testing, clinics are billing with their clinic NPI number as the billing entity for physicians working in those clinics.

(Q) Multiple AHCCCS ID #s to one NPI and vice versa could be set up to handle the community health centers - was this the intent?

(A) Not the ones we saw - it was more that we split up providers for payment arrangements - may have a community health center who has one behavioral health provider ID and a separate ID for another provider - different payment methodology.

(Q) AHCCCS is going to continue to not allow that type of transaction, right?

(A) No, we cannot - this is not up to us any more - it will be valid, for a non-provider type 01 to be the billing provider

(Q) Won't that cause a problem on Encounters?

(A) No, because right now the billing provider is not reported to us - we get the rendering provider and should continue this way - will remove the billing provider restriction and allow other provider types but will still require paperwork that includes a statement of permission, i.e., "Yes, Dr. Who can bill on my behalf."

4. Billing Provider NPIs - Issue 2 targets NPIs from organizations that are not registered. Valerie is responding individually to these organizations.
5. A-typical Providers with NPIs issue arose because atypical providers got an NPI because they "didn't know" or "didn't need" or "got just in case another provider would need it." Now, however, some of these providers do not want the NPI. Removal from the enumerator is easy, but would require that everyone who was provided with the NPI be contacted and advised to remove it from their system. The AHCCCS solution (SSR# 2007-0279) will be to let the use of the NPI be optional for A-typical providers on an ongoing basis.
6. DME Providers must have one NPI for each service location is a Medicare requirement and will be handled by Valerie.
7. Rendering Providers with multiple service locations (with unique pay to address) and tax IDs is being tested by AHCCCS to ensure everything is going to the proper location in terms of payment and remittance.
8. Medicare Rule regarding paper submission vs. electronic is in the review stage.
9. Requirement for prescribing provider at POS is being watched nationally.
10. Pay to Location Code vs. Service Provider Location Code in testing to ensure that AHCCCS sends 835s correctly.
11. Group ID - Optional for NPI Provider type change to require an NPI.
12. Multiple provider correspondence addresses, which may be specific to certain NPI #s Future tracking item.
13. Service location - physical address information Ensure AHCCCS is capturing an address off of an 837.
14. DDD Provider Type "39" is a unique provider type for DDD and is being worked on directly with DDD.

Provider List under Challenges 2 thru 6

This handout list shows how many NPIs exist for providers under challenges 2, 3, 4, 5, 6 described above.

Health Plans with other challenges not on this list should notify Lori (lori.petre@azahcccs.gov). Updates to this list will be provided in future meetings.

(Q) Re Challenge 2 - examples of multiple NPIs- can I submit any one of these NPIs.

(A) Yes, you can submit any of them, preferably the one that was submitted to you.

Note: December changes for Testing are scheduled for a December 7 promote.

HIPAA UPDATES **Mary Kay McDaniel**

Real Time Adjudication Conference (July)

There is a national push for real time adjudication. Several state Medicaid programs are forerunners and the process is apparently going very well. Another conference is scheduled for next week in Washington.

Medicaid Management Information System Conference

The August Conference focused on three areas: the new MITA process (Medicaid Information Technology Architecture), health information exchange, and state health information exchange. Arizona has an $11.7 m. technology transformation grant underway that dovetails with Arizona Healthy Connection regarding standards for information sharing.

CMS Funding

CMS is changing the parameters for funding Medicaid systems to make states accountable. CMS is also changing how they will certify Medicaid systems. Future money will be dependent upon the MITA score and how well Medicaid information technology architecture is rolled out. This change arose, in part, from realization that the funding process influenced states to build their own systems instead of using off-the-shelf software. CMS will investigate business process flow from a current and future perspective, as well as proof of outcome, and will ask such questions as "What will this new thing do for you?" and "How will you prove it once it is in-house?" What is not yet clear is how they are going to take the money back.

(Q) Regarding "money back," do you mean CMS premium versus Medicaid premium?

(A) Yes, CMS currently funds systems at 50%-75% or 90'%, depending upon stage of completion. The result was everybody got 90% in the development mode. Proof will now be required to substantiate why there is not a system out there that cannot suffice. CMS is also considering breaking the funding apart so that business analysis and requirements and the actual configuration of those systems would get 90% funding, but development would get only 50%. This is an outcome of the many failures of the states (and federal, as well). CMS will actually have to justify to Congress why they are giving and what they are giving.

HL7 Conference

Claims attachments were the hot topic - the building of policies to enable systems to reach out beyond their hospital systems across borders using HL7 messaging. Health records, under the umbrella of continuity of care, personal health, CCR, CCD, or CCS, carrying the most pertinent information about a particular patient, will be available by thumb drives, electronic mail, and/or web sites - enabling a provider or Plan to scan, throw in a transaction, and send. To see more about vocabulary and health information exchange, *see* www.ihe.net. Some states are already piloting sharing. It is recognized that not everyone in the industry will arrive at the same place at the same time with the expanded technology.

X12

A lot of changes to claim adjustment reason codes are surfacing from code committees. This topic can be followed on the web at www.wpc-edi.com. The HIPAA rule reads that, if there is no date sanctioned by the code committee, then the date to be used is the date of the transaction. In some of these transactions, the code committee did not put the *effective* date.

Because of timing differences, the codes from those who promptly got their codes changed and posted them were rejected by the trading partners who had not yet updated their code sets. An alternative plan would be to put effective and termination dates on those codes, which will have nothing to do with the effective date of the transaction but will at least give a "head's up." The hot question is to how much time to allow for updating code sets. Votes can be cast on the conference site. Reviewing the new codes coming through is highly recommended.

Paper Claim Form

The NUCC is starting another round on updating the 1500 claim form. It could take a number of years for all changes to take effect. Watching for news on this horizon is encouraged. There is a list of changes that that did not make the cut from the last go-around.

SNF Billing Issue Committee

There are a lot of skilled nursing committees that would like to see changes made. There are 4 NPRMs in different stages. The ICD10 is the furthest along.

Noteworthy Comments

- CMS is reviewing its internet policy regarding access to CMS information.
- NCPDP discovered that the dup check logic at their system does not work and that processes were overwriting. Folks were calling in who do not have NPI and were putting up new NPIs. While there were subtle differences between NPIs, they were actually for the same person. Some folks didn't know whether they were org or individual.
- The file size of downloads is straining the system at CMS. Nonetheless, it was decided to provide full files every month instead of incremental updates as is currently done. WEDI is working on this. Anyone who wants to be included in this effort can send a letter to CMS offering to help.
- A change in Tax ID does not mean that a provider has to have a new NPI. That decision is up to the provider and he/she can choose to keep the original NPI.
- There is a difference between a group and a "billing" group, as defined by NPI law. These are two separate groups. A group provider NPI means a group that is a health care service provider and can perform health care covered services.

SUMMARY **Lori Petre**

Lori will publish comparison definitions within the next few weeks, i.e., rendering versus billing, etc.

All questions and suggestions for future Consortiums should be forwarded to an email address below:

…email comments regarding NPI status to lori.petre@azahcccs.gov.
…email comments regarding HIPAA Updates to ahcccshipaaworkgroup@azahcccs.gov

Corrections to the minutes should be directed to NPIConsortiumCoordinator@azahcccs.gov.